FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012955

Facility Name: PROPHETS RIVERVIEW

Address: 310 MOSHER DRIVE (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: (815)537-5175 **Fax #** (815)537-2628

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALETA CARLSON **Telephone Number:** (605)362-3100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,620	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,551	13,194	1,136	23,881	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,551	13,194	1,136	23,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.21%

D. How many bed-hold days during this year were paid by Public Aid?
57 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,136

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	159,684	7,090	4,854	171,628		171,628		171,628			1
2	Food Purchase		113,775		113,775		113,775	(7,802)	105,973			2
3	Housekeeping	56,942	13,684		70,626		70,626		70,626			3
4	Laundry	56,543	9,939		66,482		66,482		66,482			4
5	Heat and Other Utilities			53,821	53,821		53,821	(4,320)	49,501			5
6	Maintenance	55,205	5,358	22,235	82,798		82,798	(1,969)	80,829			6
7	Other (specify):*			438	438		438	(97)	341			7
8	**TOTAL General Services**	328,374	149,846	81,348	559,568		559,568	(14,188)	545,380			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	768,901	59,199	8,368	836,468	(10,094)	826,374	(16,953)	809,421			10
10a	Therapy	58,447	789	43,785	103,021		103,021	(17,260)	85,761			10a
11	Activities	58,322	3,553	7,491	69,366		69,366	(567)	68,799			11
12	Social Services	22,077	255	1,689	24,021		24,021	(60)	23,961			12
13	Nurse Aide Training					10,094	10,094		10,094			13
14	Program Transportation			1,805	1,805		1,805		1,805			14
15	Other (specify):*	30,873			30,873		30,873		30,873			15
16	**TOTAL Health Care and Programs**	938,620	63,796	63,138	1,065,554		1,065,554	(34,840)	1,030,714			16
	C. General Administration											
17	Administrative	43,795		97,291	141,086		141,086	13,022	154,108			17
18	Directors Fees											18
19	Professional Services			5,930	5,930		5,930		5,930			19
20	Dues, Fees, Subscriptions & Promotions			8,033	8,033		8,033	(2,995)	5,038			20
21	Clerical & General Office Expenses	58,408	7,912	20,452	86,772		86,772	(5,174)	81,598			21
22	Employee Benefits & Payroll Taxes			239,961	239,961		239,961	23,244	263,205			22
23	Inservice Training & Education			11,146	11,146		11,146		11,146			23
24	Travel and Seminar			2,179	2,179		2,179		2,179			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,420	10,420		10,420	1,096	11,516			26
27	Other (specify):*			1,072	1,072		1,072	(1,072)				27
28	**TOTAL General Administration**	102,203	7,912	396,484	506,599		506,599	28,121	534,720			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,369,197	221,554	540,970	2,131,721		2,131,721	(20,907)	2,110,814			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROPHETS RIVERVIEW #0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			136,900	136,900		136,900		136,900			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			480	480		480	(480)				34
35	Rent-Equipment & Vehicles			2,944	2,944		2,944		2,944			35
36	Other (specify):*											36
37	**TOTAL Ownership**			140,324	140,324		140,324	(480)	139,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,016	2,016		2,016	(2,016)				39
40	Barber and Beauty Shops		315	2,651	2,966		2,966	(2,966)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,640	38,640		38,640		38,640			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		315	43,307	43,622		43,622	(4,982)	38,640			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,369,197	221,869	724,601	2,315,667		2,315,667	(26,369)	2,289,298			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,802)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,320)	5		5
6	Rented Facility Space	(480)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,606)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(49,523)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,731)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	37,362	sch att	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 37,362		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (26,369)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROPHETS RIVERVIEW

ID# 0012955

Report Period Beginning: 1/1/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Uniform Inc	$ (2,139)	21	1
2	Administration	(65)	21	2
3	Wanderguard	(2,758)	21	3
4	Social Serv	(60)	12	4
5	Op/Maint	(152)	6	5
6	Resident Supplies	(97)	7	6
7	Telephone	(12)	21	7
8	Activity Inc	(567)	11	8
9	Med Supplies - Part B	(3,660)	10	9
10	Public Rel - Reimb	(1,319)	20	10
11	Def Maint Exp - 2000	(1,817)	6	11
12	Dues - NonReimb	(70)	20	12
13	Presc Drugs - Reimb	(13,293)	10	13
14	Barber/Beauty Exp	(2,966)	40	14
15	Resource Dev - supplies	(200)	21	15
16	Res Dev - Newsletter	(1,072)	27	16
17	Therapy Offset - PT, OT, ST	(17,260)	10a	17
18	Purch Svc- Lab	(1,229)	39	18
19	Purch Svc- Radiology	(617)	39	19
20	Lab Fees	(170)	39	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
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72				72
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74				74
75				75
76				76
77				77
78				78
79				79
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(49,523)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,802)	0	0	0	0	0	0	0	0	0	0	(7,802)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,320)	0	0	0	0	0	0	0	0	0	0	(4,320)	5
6	Maintenance	(1,969)	0	0	0	0	0	0	0	0	0	0	(1,969)	6
7	Other (specify):*	(97)	0	0	0	0	0	0	0	0	0	0	(97)	7
8	**TOTAL General Services**	(14,188)	0	0	0	0	0	0	0	0	0	0	(14,188)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(16,953)	0	0	0	0	0	0	0	0	0	0	(16,953)	10
10a	Therapy	(17,260)	0	0	0	0	0	0	0	0	0	0	(17,260)	10a
11	Activities	(567)	0	0	0	0	0	0	0	0	0	0	(567)	11
12	Social Services	(60)	0	0	0	0	0	0	0	0	0	0	(60)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(34,840)	0	0	0	0	0	0	0	0	0	0	(34,840)	16
	C. General Administration													
17	Administrative	0	13,022	0	0	0	0	0	0	0	0	0	13,022	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,995)	0	0	0	0	0	0	0	0	0	0	(2,995)	20
21	Clerical & General Office Expenses	(5,174)	0	0	0	0	0	0	0	0	0	0	(5,174)	21
22	Employee Benefits & Payroll Taxes	0	23,244	0	0	0	0	0	0	0	0	0	23,244	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,096	0	0	0	0	0	0	0	0	0	1,096	26
27	Other (specify):*	(1,072)	0	0	0	0	0	0	0	0	0	0	(1,072)	27
28	**TOTAL General Administration**	(9,241)	37,362	0	0	0	0	0	0	0	0	0	28,121	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(58,269)	37,362	0	0	0	0	0	0	0	0	0	(20,907)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(480)	0	0	0	0	0	0	0	0	0	0	(480)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(480)	0	0	0	0	0	0	0	0	0	0	(480)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,016)	0	0	0	0	0	0	0	0	0	0	(2,016)	39
40	Barber and Beauty Shops	(2,966)	0	0	0	0	0	0	0	0	0	0	(2,966)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(4,982)	0	0	0	0	0	0	0	0	0	0	(4,982)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,731)	37,362	0	0	0	0	0	0	0	0	0	(26,369)	45

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
THE EV LUTHERAN GOOD SAMARIAN SOCIETY	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin/Acctg	$ 97,291	The Ev Lutheran Good Samaritan Society	100.00%	$ 110,313	$ 13,022	1
2	V								2
3	V	22	Unemployment	5,177			5,177		3
4	V								4
5	V	22	Workers Comp	1,944			25,188	23,244	5
6	V								6
7	V	26	Insurance	10,420			11,516	1,096	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 114,832			$ 152,194	$ * 37,362	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The Ev Lutheran Good Samaritan Society
Street Address: 4800 W 57th St PO Box 5038
City / State / Zip Code: Sioux Falls, SD 57117-5038
Phone Number: ((605)362-3100
Fax Number: ((605)362-3265

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See 'Report on Allowable Central Office Expenses for the				$	$		$	1
2		Year ended 12/31/00' submitted under separate cover								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NOT APPLICABLE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	1,369	8
	1996	1,751	9
	1997		10
	1998		11
	1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,259 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS - 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1966	$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16	schedule attached - bldg				2,011,688	87,073		87,073		1,330,582	16
17	schedule attached - land imp				53,709	3,076		3,076		34,457	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,065,397	$ 90,149		$ 90,149	$	$ 1,365,039	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 412,377	$ 39,602	$ 39,602	$	VARIOUS	$ 190,721	37
38	Current Year Purchases	35,051	2,456	2,456		VARIOUS	2,456	38
39	Fully Depreciated Assets	211,090	1,225	1,225		VARIOUS	211,090	39
40								40
41	TOTALS	$ 658,518	$ 43,283	$ 43,283	$		$ 404,267	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT CARE	Van	1992	$ 35,985	$	$	$	4	$ 35,985	42
43	RESIDENT CARE	86 Chevy Caprice Wagon	1994	4,553				2	4,553	43
44										44
45										45
46	TOTALS			$ 40,538	$	$	$		$ 40,538	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,779,453	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 133,432	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 133,432	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,809,844	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apartments Unit 40	$	$	$	52
53	Building	64,229	1,839	41,473	53
54	FFE	9,826	610	7,910	54
55					55
56					56
57	TOTALS	$ 74,055	$ 2,449	$ 49,383	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,944 Description: computer equip lease, air fluid thpy bed, miscellaneous
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 144

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 602	$	$ 602
2	Books and Supplies			146		146
3	Classroom Wages	(a)	1,537	2,678		4,215
4	Clinical Wages	(b)		1,526		1,526
5	In-House Trainer Wages	(c)				
6	Transportation		1,415	2,140		3,555
7	Contractual Payments			50		50
8	Nurse Aide Competency Tests					
9	TOTALS		$ 2,952	$ 7,142	$	$ 10,094
10	SUM OF line 9, col. 1 and 2	(e)	$ 10,094			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs	NOT APPLICABLE					#VALUE!	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 **Report Period Beginning:** 1/1/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,541	$	1
2	Cash-Patient Deposits	3,817		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance #12991)	358,231		3
4	Supply Inventory (priced at COST)	22,279		4
5	Short-Term Investments	1,008,051		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,414,919	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	2,075,918		14
15	Leasehold Improvements, at Historical Cost	53,709		15
16	Equipment, at Historical Cost	708,883		16
17	Accumulated Depreciation (book methods)	(1,859,227)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	54,177		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Asset Mgmt Purch	11,435		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,059,895	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,474,814	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 81,314	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	136,862		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	105,587		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Dep - Apt	800		36
37	Group Ins - Emp Portion/ Garnishments	(173)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 324,390	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 324,390	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,150,424	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,474,814	$	48

***(See instructions.)**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,951,248	1
2	Restatements (describe):		2
3	**Net Income - Unit 40 Apartments**	11,266	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,962,514	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	178,772	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intra-co N/A CO**	8,035	15
16	Other (describe) **Donor Rest Prop/Oper Gift - Cash**	1,101	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 187,908	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21	**Rounding**	2	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,150,424	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,477,558	1
2	Discounts and Allowances for all Levels	(268,075)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,209,483	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	15,222	5
6	Therapy	127,015	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 142,237	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	571	12
13	Barber and Beauty Care	2,756	13
14	Non-Patient Meals	11,413	14
15	Telephone, Television and Radio	11	15
16	Rental of Facility Space		16
17	Sale of Drugs	27,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,054	19
20	Radiology and X-Ray	1,022	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,876	23
	D. Non-Operating Revenue		
24	Contributions	24,007	24
25	Interest and Other Investment Income***	25,121	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,128	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nrsg & Medical Supplies	35,327	28
28a	Schedule Attached	13,388	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 48,715	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,494,439	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	559,568	31
32	Health Care	1,065,554	32
33	General Administration	506,599	33
	B. Capital Expense		
34	Ownership	140,324	34
	C. Ancillary Expense		
35	Special Cost Centers	4,982	35
36	Provider Participation Fee	38,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,315,667	40
41	**Income before Income Taxes (line 30 minus line 40)****	178,772	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 178,772	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,117	$ 40,018	$ 18.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,372	6,032	92,723	15.37	3
4	Licensed Practical Nurses	13,057	13,983	194,935	13.94	4
5	Nurse Aides & Orderlies	43,055	46,705	401,477	8.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,316	6,085	57,197	9.40	8
9	Activity Director	1,828	2,080	21,708	10.44	9
10	Activity Assistants	4,219	4,708	35,993	7.65	10
11	Social Service Workers	1,929	2,130	22,276	10.46	11
12	Dietician					12
13	Food Service Supervisor	1,799	2,089	21,848	10.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,009	18,007	139,448	7.74	15
16	Dishwashers					16
17	Maintenance Workers	5,505	5,863	54,323	9.27	17
18	Housekeepers	6,521	7,511	56,411	7.51	18
19	Laundry	6,856	7,321	55,939	7.64	19
20	Administrator	1,933	2,094	43,671	20.86	20
21	Assistant Administrator					21
22	Other Administrative	439	450	3,152	7.00	22
23	Office Manager	1,927	2,158	23,278	10.79	23
24	Clerical	2,362	2,549	20,387	8.00	24
25	Vocational Instruction					25
26	Academic Instruction	1,923	2,100	30,786	14.66	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,956	3,339	41,462	12.42	31
32	Other Health C: Mdcre Coord	830	843	12,349	14.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,836	138,164	$ 1,369,381 *	$ 9.91	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	134	$ 4,530	Line 1, col 3	35
36	Medical Director	24	1,750	line 10, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	720	line 10, col 3	39
40	Physical Therapy Consultant	429	19,336	Line 10a, col 3	40
41	Occupational Therapy Consultant	390	17,582	Line 10a, col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	153	6,867	Line 10a, col 3	43
44	Activity Consultant	42	1,610	line 11, col 3	44
45	Social Service Consultant	55	1,776	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,323	$ 54,171		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeannette Soleta	Administrator		$ 43,671
vacation accrual			124
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 43,795

B. Administrative - Other

Description	Amount
Admin/Acctg	$ 97,291
TOTAL (agree to Schedule V, line 17, col. 3)	$ 97,291
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Dept of Health	project license fee	$ 2,400
BDO Seidman	Mdcre Cost Report Prep	3,300
Good Samaritan	Mdcd Cost Report Prep	200
Contract Serv	misc	30
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,930

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,188
Unemployment Compensation Insurance	5,177
FICA Taxes	102,821
Employee Health Insurance	86,342
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Taxable Gifts Payment	23,072
Staff Pension	18,938
Employee Physicals	30
Admin/Consultant Svgs	1,636
TOTAL (agree to Schedule V, line 22, col.8)	$ 263,204

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,606
Health Care Worker Background Check	
(Indicate # of checks performed)	
Publications	1,723
Public Relations - Reimb	1,319
Dues - Reimb	3,385
Less:Dues-NonReimb	(70)
Less: Public Relations Expense	(1,319)
Non-allowable advertising	(1,606)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,038

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	365
Seminar Expense	1,814
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,179

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting - 6 res rooms	10/00	$ 1,913	5	$	$	$	$ 96	$ 383	$ 383	$ 383	$ 381	$ 287
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,913		$	$	$	$ 96	$ 383	$ 383	$ 383	$ 381	$ 287

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **$2844 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 yr**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,424** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **38,640**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **ye** Indicate the amount. $ **7,802**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **31%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Henry Scholten & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.